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SUPREME COURT OF APPEALS
CHARLESTON, WEST VIRGINIA

JOHN J. LOVAS,

Claimant-Appellant,

vs.

CONSOLIDATION COAL COMPANY,

Self-Insured Employer.

: SUPREME COURT NO.:_____
: BOARD OF REVIEW NO.: 78056
: CLAIM NO.: 2000011537
: DOI: 08/25/1999
: BOR Decision: 04/11/2007
: ALJ Decision: 08/24/2006
: OOJ Case Id. No. OOJ- A200-011537

PETITION AND BRIEF OF THE CLAIMANT, JOHN LOVAS IN SUPPORT OF HIS APPEAL

M. Jane Glauser, Esquire (WVSB # 1397)
SCHRADER BYRD
& COMPANION, PLLC
The Maxwell Centre
32-20th Street, Suite 500
Wheeling, West Virginia 26003
(304)233-3390

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INDEX

I. STATEMENT OF THE RULINGS OF THE COMPENSATION COMMISSIONER ON THE CLAIMS OF THE CLAIMANT [Exhibit A]:

On September 30, 1999, the claim was ruled compensable.

On October 27, 1999, the Division authorized EMG studies.

On November 24, 1999, the Division authorized a consultation with Dr. Joseph Maroon.

On July 26, 2000, the Division authorized a pain management program.

On September 7, 2000, the Division authorized six weeks of work conditioning.

On September 11, 2000, the Division granted rehabilitation benefits from July 31, 2000 through September 17, 2000.

On September 12, 2000, the Division closed the claim for temporary total disability benefits. The Claimant protested.

On November 10, 2000, the Division authorized a stress test. The employer protested.

On December 6, 2000, the Division closed the claim for rehabilitation benefits, because the Claimant had returned to work. The Claimant protested.

On February 16, 2001, the Division referred the Claimant to Dr. Kip Beard for an evaluation.

On February 26, 2001, the Division closed the claim for temporary total disability benefits.

On April 16, 2001, the Office of Judges reversed the order of September 12, 2000 which closed the claim for temporary total disability.

On July 11, 2001, the Office of Judges affirmed the order of November 10, 2000 which authorized a stress test and affirmed the order of December 6, 2000 which closed the claim for rehabilitation benefits.

On October 12, 2001, the Division granted a 7% permanent partial disability award, based upon the report by Dr. Beard. The Claimant protested.

By decision dated February 22, 2002, the Office of Judges reversed the order of October 12, 2001, granting a 7% PPD award and granted a 19% PPD award. This decision was affirmed by the Board of Review on June 11, 2003. The Employer appealed, but the Supreme Court declined the appeal by order entered on December 22, 2004, in Docket No. 031357.

The claimant protested the claims administrator's Order dated February 22, 2006, which closed the claim administratively for medical treatment "because our records reflect **your last date of service was January 21, 2002."** The claimant protested. The administrative closure order of February 22, 2006 was approved by the decision entered on August 22, 2006, by the Office of Judges. The Claimant filed a timely appeal. The Board of Review issued a decision on April 11, 2007, affirming the decision by the Office of Judges.

II. STATEMENT OF THE NATURE AND THE EXTENT OF THE INJURY AND HOW THE INJURY WAS CAUSED:

A. Age, Education and Work History:

The claimant was born on February 3, 1952. The claimant graduated from high school in 1969, and attended three (3) years of college. The claimant has worked in the mining industry for approximately thirty (30) years. He is working as a mechanic for Consolidation Coal, Shoemaker Mine.

B. Medical Evidence:

1. Dr. Kip Beard:

This examiner for the Division filed a report dated April 25, 2001, for his exam of the same date.

This examination for lumbosacral sprain revealed mild left-sided paravertebral muscular spasm. There was diminished straight leg raising. His range of motion findings were as follows:

Lateral right flexion	20°
Lateral left flexion	20°

He rated the Claimant with a five percent (5%) impairment from Table 75, II B, of the 4th Edition of the AMA Guides. He combined this rating with two percent (2%) for range of motion, for a total of seven percent (7%) permanent impairment.

2. Dr. James Wiley:

On February 21, 2002, Dr. Wiley, an orthopedic examiner, filed a report for an examination on February 20, 2002, at the request of the Claimant.

Dr. Wiley found minimal atrophy of the left thigh. Reflexes were active at the right ankle, but hypoactive of the left ankle. Dr. Wiley found diminished sensation in the area of the left lateral calf, suggesting an L5 nerve root condition.

His range of motion of the lumbar spine were as follows:

Flexion	5% (30°)
Extension	5% (11°)
Lateral flexion	1% (20°)
Left lateral flexion	1% (20°)
	12%

Dr. Wiley found narrowing of multiple disc spaces at L2-L3, L3-L4, and L5-S1, by x-rays taken in his office. These x-rays also revealed osteophytic changes in the lumbar spine, with the worst findings at L2-L3. Lateral flexion x-rays revealed mild further flexion.

His impression was a lumbar sprain type injury with lumbar disc displacement with radiculopathy.

Dr. Wiley concluded that the Claimant had mild compromise of the neuroforaminal exit area on the left at L3-L4 by the CT scan. He also found a diminished left ankle jerk and sensory loss of the left lateral calf.

According to Dr. Wiley the Claimant had the following impairment of the lumbar spine:

Table 75, II, C	7%
Range of Motion	12%
Neurological	

Diminished left ankle jerk Diminished sensation/left calf	1%
TOTAL	19%

A supplemental report was filed on September 9, 2002. He noted that the Claimant had lumbar disc displacement with radiculopathy based upon a diminished left ankle jerk as well as prior evaluation by Dr. David Liebeskind and a neurosurgeon.

Dr. Wiley also again stated that the Claimant had valid range of motion testing.

3. Dr. Victoria Langa:

On July 26, 2002, this examiner for the employer filed her report for the examination of the Claimant on July 12, 2002.

Dr. Langa found that the Claimant failed the validity test for range of motion testing for flexion and extension. Rotation was 20° bilaterally, and lateral flexion of 20° bilaterally. She found no atrophy and bilateral equal reflexes. She found a "well circumscribed area of mildly altered sensation over the lateral upper to mid lower leg in the distribution of a portion of the lateral sural cutaneous nerve, which she found did not follow a clear nerve root or dermatomal pattern.

Dr. Langa did not review any x-rays except for the lumbar spine series of July 12, 2002, which revealed some early degenerative changes at the facet joints bilaterally at L5-S1. Her diagnosis was "status-post soft tissue injury, lumbosacral spine," with early degenerative disease at L5-S1.

Dr. Langa concluded that the Claimant had age related degenerative disc disease/ degenerative joint disease of the lumbar spine. She found no impairment rating based on Table 75 at page 113. The range of motion impairments were as follows:

Left rotation	1%
Right rotation	1%
Left lateral flexion	1%
Right lateral flexion	1%
RANGE OF MOTION:	4%

On her back examination form, Dr. Langa concluded that there was no evidence of symptom magnification.

Dr. Langa testified on September 23, 2002. She did not have prior x-rays films to review, so x-rays were taken as part of her exam. (T. 8-9). She could not apportion impairment between the two work injuries to his back. (T. 9-10).

She noted multiple levels of disc involvement from L2-L3, L3-L4, L4-L5, and L5-S1, with "maybe. . . two or three levels of involvement." (T. 11-12).

Dr. Langa did not take flexion-extension x-rays, such as those by Dr. Wiley. (T. 13). She noted radiculopathy might be "coming and going" and vary from examiner to examiner. (T. 14-15).

Dr. Langa did not place the Claimant into any category under Table 75, as did Dr. Beard and Dr. Wiley. (T. 20-21). She did not believe it was appropriate to use Table 75 "for pre-existing diffuse degenerative disease." (T. 22).

C. Affidavit of Payment by the Third Party Administrator [Exhibit B]:

The self insured employer filed a response to order to compel dated March 29, 2006, which enclosed an affidavit of payment which was alleged to have been made on January 21, 2002, which is also the last date of medical service according to the underlying order. There was no identification of the record or nature of the medical service and treatment, and whether the treatment was ongoing or contained recommendations for future treatment. The date of payment and the date of last medical service are alleged to be the same date, which is highly unlikely.

III. ASSIGNMENTS OF ERRORS:

The Claimant respectfully assigns as errors the decisions by the Board of Review on April 11, 2007, and by the Office of Judges on August 24, 2006, which affirmed the administrative closure of the claim for medical treatment by order dated February 22, 2006, pursuant to 85 CSR 1-14.1.

The Claimant had filed an appeal to the Board of Review from the decision by the Office of Judges entered on August 24, 2006, which affirmed the third party administrative order of February

22, 2006, which closed the claim administratively for medical treatment. The Claimant had requested that the Board of Review find that the claim should remain open for medical treatment.

The Board of Review erred, as did the Office of Judges, by failing to reverse the order of February 22, 2006, by the third party administrator closing the claim administratively for medical evidence and also by failing to remand the claim for further evidentiary proceedings on the need for continuing treatment, since the claimant had been granted a 19% permanent partial disability award in this claim and the third party administrator also failed to produce the relevant records concerning medical treatment. The Office of Judges and the Board of Review erred by failing to remand the claim on this issue alone.

The Claimant further submits that the administrative regulation at 85 CSR 1-14.1 for closure of a claim is contrary to West Virginia Code, Section 23-4-16, permitting medical treatment for five years from the date of the last significant treatment and also contrary to the underlying legislative policy to provide medical care promptly and which is reasonably required.

IV. STATEMENT OF THE POINTS OF LAW AND CITATIONS OF AUTHORITY RELIED UPON BY THE CLAIMANT:

A. Standard of Review:

1. Statutory Authority:

a. West Virginia Code, Section 23-4-1g, as to the weighing of evidence, provides:

> For all awards made on or after the effective date of the amendment and re-enactment of this section during the year two thousand three, resolution of any issue raised in administering this chapter shall be based on a weighing of all evidence pertaining to the issue and a finding that a preponderance of the evidence supports the chosen manner of resolution. The process of weighing evidence shall include, but not be limited to, an assessment of the relevance, credibility, materiality and reliability that the evidence possesses in the context of the issue presented. Under no circumstances will an issue be resolved by allowing certain evidence to be dispositive simply because it is reliable and is most favorable to a party's interests or position. **If, after weighing all of the evidence regarding an issue in which a claimant has an interest, there is a finding that an equal amount of evidentiary weight exists favoring conflicting matters for resolution, the resolution that is most consistent with the claimant's position will be adopted**. [Emphasis added.]

b. West Virginia Code, §23-5-12, provides that the Appeal Board shall reverse, vacate or modify the decision of the Administrative Law Judge if the substantial rights of the appellant have been prejudiced because the findings are:

(1) In violation of statutory provisions; or
(2) In excess of the statutory authority or jurisdiction of the administrative law judge; or
(3) Made upon unlawful procedures; or
(4) Affected by other error of law; or
(5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; or
(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

c. West Virginia Code, Section 23-5-15 provides as follows:

c) If the decision of the board represents an affirmation of a prior ruling by both the commission and the office of judges that was entered on the same issue in the same claim, the decision of the board may be reversed or modified by the supreme court of appeals only if the decision is in clear violation of constitutional or statutory provision, is clearly the result of erroneous conclusions of law, or is based upon the board's material misstatement or mischaracterization of particular components of the evidentiary record. The court may not conduct a de novo re-weighing of the evidentiary record. If the court reverses or modifies a decision of the board pursuant to this subsection, it shall state with specificity the basis for the reversal or modification and the manner in which the decision of the board clearly violated constitutional or statutory provisions, resulted from erroneous conclusions of law, or was based upon the board's material misstatement.

(d) If the decision of the board effectively represents a reversal of a prior ruling of either the commission or the office of judges that was entered on the same issue in the same claim, the decision of the board may be reversed or modified by the Supreme Court of Appeals only if the decision is in clear violation of constitutional or statutory provisions, is clearly the result of erroneous conclusions of law, or is so clearly wrong based upon the evidentiary record that even when all inferences are resolved in favor of the board's findings, reasoning and conclusions, there is insufficient support to sustain the decision. The court may not conduct a de novo re-weighing of the evidentiary record. If the court reverses or modifies a decision of the board pursuant to this subsection, it shall state with specificity the basis for the reversal or modification and the manner in which the decision of the board clearly violated constitutional or statutory provisions, resulted from erroneous conclusions of law, or was so clearly wrong based upon the evidentiary record that even when all inferences are resolved in favor of the board's findings, reasoning and conclusions, there is insufficient support to sustain the decision.

2. Cases:

a. An order of the Appeal Board, approving an order of the Commissioner, will be reversed by the Supreme Court of Appeals, when the legal conclusions of the Appeal Board are erroneous. Emmel v. Comm'r., 150 W.Va. 277, 145 S.E.2d 29 (1965).

b. When a decision by the Appeal Board is based on evidence which is speculative and is inadequate to sustain a claim, then such decision is not supported by the evidence and for that reason is clearly wrong and should be reversed. Smith v. Comm'r., 155 W.Va. 883, 189 S.E.2d 838 (1972).

c. A decision of the Appeal Board will be reversed by the Supreme Court of Appeals when it is not supported by the evidence or when the legal conclusions of the Appeal Board are erroneous. Clark v. Comm'r., 155 W.Va. 726, 187 S.E.2d 213 (1972).

d. A finding of fact by the Appeal Board is not to be disturbed unless shown to be clearly wrong. However, this rule is not applicable when the facts are undisputed, and the record will admit of reasonable inferences favorable to the claimant. Morris v. Comm'r., 135 W.Va. 425, 64 S.E.2d 496 (1951); Pirlo v. Comm'r., 161 W.Va. 296, 242 S.E.2d 452 (1978).

e. The findings of fact by the Appeal Board are conclusive only if the findings are not manifestly against the weight of the evidence. Emmel v. Comm'r., 150 W.Va. 277, 145 S.E.2d 29 (1965).

f. The rulings of the Appeal Board will not be reversed unless there is error of law or when the findings are clearly against the preponderance of the evidence. Gibson v. Comm'r., 127 W.Va. 97, 31 S.E.2d 555 (1944); Estep v. Comm'r., 130 W.Va. 504, 44 S.E.2d 305 (1947); Barnett v. Comm'r., 153 W.Va.796, 172 S.E.2d 698 (1970); Barkley v. Comm'r., -W.Va.-, 266 S.E.2d 456 (1980).

g. If the decision of the Appeal Board "appears clearly to have been wrong," "is clearly wrong," "is plainly wrong" or "where the facts are undisputed, and the record will admit of reasonable inferences favorable to the claimant," such decision will be set aside. McGeary v. Comm'r., 148 W.Va. 436, 135 S.E.2d 345 (1964).

h. While the findings of fact of the Appeal Board are conclusive, unless they are manifestly against the weight of the evidence, the legal conclusions of the Appeal Board, based upon such findings, are subject to review by the Supreme Court. Barnett v. Comm'r., 153 W.Va. 796, 172 S.E.2d 698 (1970).

i. A decision of the Appeal Board will be reversed by the Supreme Court when it is not supported by the evidence or when the legal conclusions of the Appeal Board are erroneous. Hamrick v. Comm'r., 159 W.Va. 840, 228 S.E.2d 702 (1976); Bias v. Comm'r., 176 W.Va. 421, 345 S.E.2d 23 (1986).

B. Issue Presented:

1. West Virginia Code:

a. Section 23-4-3

b. Section 23-5-9

c. Section 23-5-12

d. Section 23-5-13

2. Cases:

a. Maikotter v. University of W.Va. Bd. of Trustees, 206 W.Va. 691, 527 S.E.2d 802 (1999).

b. Meadows v. Lewis, 172 W.Va. 457, 307 S.E.2d 625 (1983)

c. Rowe v. W.Va. Dept. of Corrections, 170 W.Va. 230, 292 S.E.2d 650 (1982)

d. Sisk v. Comm'r., 153 W.Va., 461, 1970 S.E.2d 20 (1969)

e. State ex rel McKenzie v. Smith, 212 W. Va. 288, 569 S.E.2d 809 (2002)

V. ARGUMENT:

A. Issue Presented: Whether the lower tribunals erred in affirming the decision of the third party administrator dated February 22, 2006, closing the claim administratively for medical treatment.

B. Discussion of Authority:

The third party administrator alleged that the date of payment for the last medical service is the triggering date, as set forth in Exhibit B, but the regulation 85 CSR 1-14.1 clearly provides and the date of the last medical service is the triggering event. The date of payment for the last medical service and the date of last medical services are not the same.

The ALJ reasons at pages 3- 4 of the decision dated August 24, 2006, that the "only potential adverse effect upon the claimant is that the claimant would have to submit a reopening request to the administrator before additional treatment may be approved." Since there are medical treatment procedures, such as office visits which do not require "prior authorization," the administrative closure does in fact create additional burdens upon the claimant since the physician and the claimant would need to file to reopen a claim, even to obtain an office visit

under the administrative closure rule. This creates a dilemma for both the claimant and the physician when the payment for services at this initial office visit becomes an issue.

The Office of Judges has outlined this administrative burden at pages 3-4 of the decision dated August 24, 2006, as follows:

> It has been further suggested that the protested Order requires that the claimant submit a claim reopening application to reopen the claim for medical benefits and that this is contrary to the law. The argument that has been advanced is that a reopening application is only required when reopening for additional temporary total, permanent partial or permanent total disability benefits and that those specific reopening requests are limited to two attempts.
>
> After due deliberation, the adjudicator finds as follows: First, 85 CSR 1 Section 14.1 in not contrary to the provisions of W.Va.. Code Section 23-4-16(a)(4). The regulation deals only with administrative closure of the claim. W.Va. Code, Section 23-4-16 and its various subsections bar a claim from being reopened after the applicable time provisions have expired. The Code section does not state when a claim may be closed; it merely states for how long and when, a claim may be reopened. There is a significant difference between a claim being administratively closed for treatment and being barred for further treatment. In support of this interpretation, the protested Order expressly acknowledges the claimant's right to attempt to reopen the claim for treatment in the future.
>
> Furthermore, there is no adverse effect foreseen to the claimant since the claimant may still reopen his claim for additional treatment and the number of reopening requests for additional treatment is not limited by statute. The only limitation on the reopening for additional treatment is the time limitation of five year [sic] from last significant treatment.
>
> The only potential adverse effect upon the claimant is that the claimant would have to submit a reopening request to the administrator before additional treatment may be approved. However, additional treatment could not be approved, even under the system in place before the Rule was adopted, without the filing of a request for approval and some showing that the claimant required treatment that he or she did not require before. The pre-Rule system required a *de facto* "reopening" of the claim in order to obtain additional treatment. Therefore, the reopening request requirement imposed by the Rule is, in actuality, no more restrictive of the claimant than the pre-Rule system.

The Claimant, John Lovas, has been granted a 19% PPD award in this claim. Accordingly, by the terms of 85 CSR 1 § 14, the claim cannot be administratively closed, because the regulation provides for closure *only* when the claim is a no lost time claim or a claim closed for TTD, as follows:

> 14.1. Medical benefits in all no lost time claims and claims for temporary total disability benefits shall cease and the claim administratively closed six (6) months after the last date of service in the claim....[Emphasis added.]

The regulation 85 CSR §14 conflicts directly with West Virginia Code § 23-4-16 (a)(4) which provides as follows:

> With the exception of the items set forth in subsection (d), section three of this article, in any claim in which medical or any type of rehabilitation service has not been rendered or durable medical goods or other supplies have not been received for a period of five years, no request for additional medical or any type of rehabilitation benefits shall be granted nor shall any medical or any type of rehabilitation benefits or any type of goods or supplies be paid for by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, if they were provided without a prior request. For the exclusive purposes of this subdivision, medical services and rehabilitation services shall not include any encounter in which significant treatment was not performed.

This code provision specifically states that claims shall remain open for a period of five (5) years and can only be closed if "significant treatment was not performed" during this time frame. However, 85 CSR 1 § 14 states as follows:

> 14.1. Medical benefits in all no lost time claims and claims for temporary total disability benefits shall cease and the claim administratively closed six (6) months after the last date of service in the claim. A protestable order shall be issued by the Commission or private carrier upon said administrative closure. Nothing in this provision shall be deemed to abridge an injured worker's right to attempt to reopen the claim at a later date under applicable law. [Emphasis added.]

The statute must prevail over the more restrictive language of the regulation. The West Virginia Supreme Court has held in Points 9 and 10 of the Syllabus of the Court, in State ex rel McKenzie v. Smith, 212 W. Va. 288, 569 S.E.2d 809 (2002), as follows:

> 9. "Any rules or regulations drafted by an agency must faithfully reflect the intention of the Legislature, as expressed the controlling legislation. Where a statute contains clear and unambiguous language, an agency's rules or regulations must give that language the same clear and unambiguous force and effect that the language commands in the statute." Syllabus Point 4, Maikotter v. University of W.Va. Bd. of Trustees, 206 W.Va. 691, 527 S.E.2d 802 (1999).

10. "It is fundamental law that the Legislature may delegate to an administrative agency the power to make rules and regulations to implement the statute under which the agency functions. In exercising that power, however, an administrative agency may not issue a regulation which is inconsistent with, or which alters or limits its statutory authority." Syllabus Point 3, Rowe v. W.Va. Dept. of Corrections, 170 W.Va. 230, 292 S.E.2d 650 (1982).

The agency regulation is in direct conflict with the statute and should not be enforced. While it appears that this agency rule attempts to avoid violating W. Va. Code § 23-4-16 (a)(4) with the language in the final sentence, BrickStreet Administrative Services and third-party administrators are issuing these letters explaining a procedure that a claimant must file a petition to reopen for medical treatment, which is contrary to the statute. The only requirement by statute is that the treatment should be "reasonably required."

There is no statutory authority to discontinue medical treatment when a claimant reached maximum medical improvement. The only requirement for the medical care is that it be reasonably required. It is provided for the payment of medical services and treatment as follows:

> West Virginia Code, **§23-4-3. Schedule of maximum disbursements for medical, surgical, dental and hospital treatment; legislative approval; guidelines; preferred provider agreements; charges in excess of scheduled amounts not to be made; required disclosure of financial interest in sale or rental of medically related mechanical appliances or devices; promulgation of rules to enforce requirement; consequences of failure to disclose; contract by employer with hospital, physician, etc., prohibited; criminal penalties for violation; payments to certain providers prohibited; medical cost and care program; payments; interlocutory orders.**
>
> (a) The Workers' Compensation Commission, and effective upon termination of the commission, the Insurance Commissioner, shall establish and alter from time to time, as it determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care providers, providers of rehabilitation services, providers of durable medical and other goods and providers of other supplies and medically related items or other persons, firms or corporations for the rendering of treatment or services to injured employees under this chapter. The commission and effective upon termination of the commission, the Insurance Commissioner, also, on the first day of each regular session and also from time to time, as it may consider appropriate, shall submit the schedule, with any changes thereto, to the Legislature.
>
> The commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, shall disburse and pay for

personal injuries to the employees who are entitled to the benefits under this chapter as follows:

> (1) Sums for health care services, rehabilitation services, **durable medical and other goods and other supplies and medically related items as may be reasonably required**. The commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, shall determine that which is reasonably required within the meaning of this section in accordance with the guidelines developed by the health care advisory panel pursuant to section three-b of this article....**Each health care provider who seeks to provide services or treatment which are not within any guideline shall submit to the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, specific justification for the need for the additional services in the particular case and the commission shall have the justification reviewed by a health care professional before authorizing the additional services...**[Emphasis added.]

Rule 85 CSR 1.14.1 does in fact create additional administrative burdens for medical treatment upon a system already burdened by litigation over medical treatment in a climate where few medical providers are willing to accept claimants for treatment, especially when a claim is administratively closed for medical treatment. The regulation requires a claim reopening application for medical treatment. The reopening of a claim for medical treatment can be denied, thus requiring litigation as to the right to reopening for medical treatment, and then followed by subsequent litigation over the medical reasonableness and the necessity of the requested medical treatment. This rule simply adds additional administrative delay to an already over-burdened administrative system. This now occurs when treatment is denied because a Diagnosis Update has not been filed or has been filed but ignored, and the medical reasonableness and necessity of treatment cannot be addressed as relevant because the issue of the Diagnosis Update must be litigated first.

The legislative policy behind the workers compensation statute is to provide prompt and reasonably required medical care; additionally, legislative policy is that the rights of the injured worker shall not be denied due to technicalities. In Ney v. Comm'r., -W. Va.-, 297 S.E.2d 212 (1982), the Supreme Court of Appeals observed that one of the basic purposes of workers

compensation legislation is to impose upon industry, the cost of medical expenses incurred in the treatment and rehabilitation of workers who have suffered injuries in the course of and as a result of their employment. The six month administrative policy rule at 85 CSR 1-14.1 clearly defeats this policy.

At West Virginia Code, Section 23-5-13, this policy is expressed in the following manner:

> **§23-5-13. Continuances and supplemental hearings; claims not to be denied on technicalities.**
>
> It is the policy of this chapter that the rights of claimants for workers' compensation be determined as speedily and expeditiously as possible to the end that those incapacitated by injuries and the dependents of deceased workers may receive benefits as quickly as possible in view of the severe economic hardships which immediately befall the families of injured or deceased workers. Therefore, the criteria for continuances and supplemental hearings "for good cause shown" are to be strictly construed by the chief administrative law judge and his or her authorized representatives to prevent delay when granting or denying continuances and supplemental hearings. It is also the policy of this chapter to prohibit the denial of just claims of injured or deceased workers or their dependents on technicalities.

The Supreme Court has previously held that the claimant should not be penalized for delays and that such delays are not consistent with the legislative policy for speedy and expeditious payment of benefits. Meadows v. Lewis, 172 W.Va. 457, 307 S.E.2d 625 (1983).

The administrative closure rule is simply not the system intended by the Legislature. For example, at West Virginia Code, Section 23-4-7, the Legislature expressed :

> **§23-4-7a. Monitoring of injury claims; legislative findings; review of medical evidence; recommendation of authorized treating physician; independent medical evaluations; temporary total disability benefits and the termination thereof; mandatory action; additional authority; suspension of benefits.**
>
> (a) The Legislature hereby finds and declares that injured claimants should receive the type of treatment needed **as promptly as possible**; that overpayments of benefits with the resultant hardship created by the requirement of repayment should be minimized; and that to achieve these two objectives it is essential that the commission establish and operate a systematic program for the monitoring of injury claims where the disability continues longer than might ordinarily be expected. [Emphasis added.]

In addition to the above, the Commission has failed to supply all the necessary "relevant" documents for the litigation of the claim. It is provided at 93 CSR 7.5B requires:

> Subject to the limitations set forth in this Rule, the following documents from the claim files shall be considered relevant to the protest and shall be a part of the record in every protest:
>
> ***
>
> 2. Any document, report, or request for benefit specifically referred to in the order; and

It is further provided at 93 CSR 7.5C:

> The Office of Judges shall compel the employer (through its claims administrator) to produce those relevant documents identified in paragraphs one through four of the subsection 7.5(B) [93-1-7.5(B)(1-4)]. Failure to produce the compelled documents will be considered as evidence of interference with due process in the final resolution of the matter. Incidents of failure to comply, and evidence of deliberate withholding of documents subject to an Order to Compel, shall be reported to the Insurance Commission for possible administrative sanctions. If the employer, through its claims administrator, fails to produce the relevant documents, then the Office of Judges may, in its discretion, impose any of the following sanctions:
>
> (1) Decide the issue against the non-cooperating party;
>
> (2) Issue an order dismissing the protest of the non-cooperating party;
>
> (3) Take other actions justified.

The failure to produce the medical record of treatment upon which the denial is based in order to calculate the six months is a basis for a remand of this claim. If treatment has been rendered and a bill not yet submitted or perhaps denied for administrative reasons, then the record would indicate that treatment has been rendered. A physician also has six months to

submit a bill for medical services, such that the date of the service may not be submitted to the third party administrator, within six months of the date of service.

The legislature, and even the administrative authorities, have clearly contemplated that claims periodically and routinely require updating of both the diagnoses and the medical treatment required. As such, that is the procedure which should be followed. Accordingly, the adoption of 85 CSR 1-14.1 clearly was unnecessary and contrary to the legislative policy. For example, Rule 6.6 of Rule 20: Medical Management of Claims §85-20-6, the Rules of the Treating Physician, provides as follows:

> 6.6. It is the responsibility of the treating physician to notify the Commission of the injured worker's most accurate and current condition. The initial diagnosis reported when a claim is filed **often requires updating** based on diagnostic tests and clinical objective findings. **Changes, additions and revisions** of the injured worker's condition must be reported using the applicable Commission form. All changes related to diagnosis code shall be submitted to the Commission and must be approved by the Commission, unless the new diagnosis is otherwise accepted by the Commission as being causally related to the compensable injury. Bills submitted for treatment that is clearly unrelated to the compensable diagnosis shall be denied and may serve as evidence of abuse under the West Virginia Code Section 23-4-3c and/or fraud under West Virginia Code Section 23-4-24g. The Commission may, in its sole discretion, recognize and identify the change, addition, or revision as a compensable condition. [Emphasis added.]

Under the procedures of 85 CSR 1-14.1, if a claim is administratively closed, the claimant and his provider must now prove: (1) establish that a claim can or should be reopened for medical services; and (2) whether the medical service itself is "reasonably required."

In fact, another issue arises since Rule 20 provides for and permits treatment that does not require prior authorization, inter alia, as follows:

> 9.9. Pre-authorization. Written authorization must be obtained from the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, in advance for the procedures and services listed below, except in emergencies or where the condition of the patient, in the opinion of the medical vendor, is likely to be endangered by delay. Failure to comply with this rule

will result in disapproval of the medical vendor's bill. The vendor shall not seek reimbursement from the injured worker if payment is denied under this provision. This rule does not apply in cases involving initial treatment.

9.10. The following services require prior review and authorization before services are rendered and reimbursement made:

a. Inpatient hospitalizations subsequent to the Date of Injury (emergency admissions are reviewed on a retrospective basis);

b. Transfers from one hospital to another hospital (emergencies do not require authorization);

c. Reconstructive and restorative surgeries;

d. All surgeries;

e. Purchase of TENS unit above the amount of $50.00;

f. Treatment/supplies used in excess of three (3) months for TENS units;

g. Psychiatric treatment (does not include the initial psychiatric consultation);

h. Physical Medicine treatment in excess of this Rule;

I. Outpatient pain management procedures (epidural steroids, facet injections, etc.);

j. Medication not normally used in injury treatment and medication not listed on the preferred drug list, if applicable;

k. Medication - Controlled Substance (in excess of this Rule);

l. Durable Medical Equipment in excess of $500.00;

m. Brainstem evoked audiometry;

n. Repeat diagnostic studies (Workers' Compensation no longer requires approval for the initial MRI, CAT scan, Myelogram, EMG, and Nerve Conduction Studies);

o. Standard/analog hearing aids;

p. Programmable/digital hearing aids;

q. Replacement hearing aids;

r. Repair of hearing aids over the price of $250.00;

s. Hearing Aid batteries over the allowed quantity of 50 per 6 months;

t. Telephone amplification devices;

u. Hearing aid assistance products (V5299);

v. Non-emergency ambulance transportation;

w. Non-emergency air transportation;

x. All vision services and items associated with vision;

y. All physical and vocational rehabilitative services;

z. Retraining expenses;

aa. All oxygen equipment, supplies, and related services;

bb. All nursing, nursing home, and personal care services;

cc. Home or vehicle modifications;

dd. Work hardening;

ee. Work conditioning; and

ff. Dental procedures.

9.11. Prior-authorization requests shall be made in writing or electronically to the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, for approval.

9.12. **Medical services not specified above do not require prior approval but will be reviewed retrospectively to determine medical necessity**. Services provided on an emergency basis are also subject to retrospective review to validate that the service was truly an emergency, and to determine medical necessity and relationship to the compensable injury. [Emphasis added.]

If a rule requires no prior approval nor pre-authorization, then there should not be a procedure pursuant to Rule 85 CSR 1 § 14.1 to pursue a "reopening" procedure for medical treatment, if medical treatment has not been rendered in six months. For example, an office visit is not listed as a procedure requiring prior approval or authorization, but if a claim is administratively closed, then the office visit may not be paid, even though prior approval is not required, and a reopening procedure would need to be initiated under Rule 14.1 if the claim is administratively closed for medical treatment.

Similarly, delay in the processing of medical treatment can result from a denial of medical treatment, followed by litigation and lengthy appellate procedures. Medical service and treatment could be denied at the initial level by the Commission or by the third party administrator, followed by a protest and then by lengthy appellate procedures before the Board of Review and the Supreme Court. If the claimant is eventually found to be entitled to medical treatment, perhaps after several years of litigating and appealing the denial of the treatment (or if granted treatment but which treatment is stayed pursuant to Rule 1 by the appeals of the Employer or the Insurance Commission from the Office of Judges to the Board of Review) , then the six month administrative closure pursuant to Rule 85 CSR 1 § 14.1 could easily close a claim for medical treatment "reasonably required. " Even treatment granted by the Office of Judges, but

stayed and not implemented pending the appeal by the Employer and/or the Insurance Commission to the Board of Review until the litigation and appeal process is finalized, could become the basis of the last treatment for the administrative closure of the claim. Therefore, the statutory prohibition in West Virginia Code, Section 23-4-16, which closes a claim after five years when there is no significant medical treatment, is much less of a burden to the parties and an already overburdened administrative system. The five year statutory closure rule is more easily processed to identify such claims under the administrative system then the six month administrative closure rule.

It has also been provided by the Legislature, in West Virginia Code, Section 23-4-9, that prior authorization is not required in the following circumstances:

> (b) In cases where an employee has sustained a permanent disability, or has sustained an injury likely to result in temporary disability as determined by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall at the earliest possible time determine whether the employee would be assisted in returning to remunerative employment with the provision of rehabilitation services and if it is determined that the employee can be physically and vocationally rehabilitated and returned to remunerative employment by the provision of rehabilitation services including, but not limited to, vocational or on-the-job training, counseling, assistance in obtaining appropriate temporary or permanent work site, work duties or work hours modification, by the provision of crutches, artificial limbs or other approved mechanical appliances, or medicines, medical, surgical, dental or hospital treatment or other services which the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, in its sole discretion determines will directly assist the employee's return to employment, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall immediately develop a rehabilitation plan for the employee and, after due notice to the employer, expend an amount necessary for that purpose: *Provided,* That the expenditure for vocational rehabilitation shall not exceed twenty thousand dollars for any one injured employee: *Provided, however,* That no payment shall be made for such vocational rehabilitation purposes as provided in this section unless authorized by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, prior to the rendering of the physical or vocational rehabilitation, **except that payments shall be made for reasonable medical expenses without prior authorization if sufficient evidence exists which would relate the treatment to the injury and**

the attending physician or physicians have requested authorization prior to the rendering of the treatment:....[Emphasis added.]

The rule of 85 CSR 1.14.1 thus places an administrative burden upon the claimant to "reopen" the claim for medical treatment, which reopening procedure is not set forth in the statute, but also which reopening requirement is contrary to the statute itself.

VI. CONCLUSION:

The Claimant requests that the Supreme Court should REVERSE the decision dated April 11, 2007, by the Board of Review, which decision affirmed the decision dated August 24, 2006, by the Office of Judges; that the claim remain open for medical treatment; in the alternative, that the claim be remanded for further evidentiary development on the medical treatment last rendered; and for such further relief as to the Supreme Court may seem just and proper.

John Lovas, Claimant

By: _____
M. Jane Glauser, Counsel for Claimant

M. Jane Glauser, Esquire (WVSB#1397)
SCHRADER BYRD
& COMPANION, PLLC
The Maxwell Centre
32-20th Street, Suite 500
Wheeling, West Virginia 26003
(304)233-3390

CERTIFICATE OF SERVICE

Service of the foregoing Petition and Brief of the Claimant, John Lovas, in Support of His Appeal, was had upon the parties herein by mailing true and correct copies thereof by regular United States mail, postage prepaid and properly addressed this 9th day of May, 2007, as follows:

Edward M. George, Esq.
60-14th Street
Wheeling, WV 26003

John Lovas, Claimant

BY

Of Counsel for Claimant

M. Jane Glauser, Esquire (WVSB #1397)
SCHRADER BYRD& COMPANION, PLLC
The Maxwell Centre
32-20th Street, Suite 500
Wheeling, West Virginia 26003
(304)233-3390